

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/27/2015
NAME OF PROVIDER OR SUPPLIER WINDSOR RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00178672</p> <p>Compliant IN00178672- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: July 27, 2015</p> <p>Facility number: 004001 Provider number: 004001</p> <p>Census bed type: Residential: 39 Total: 39</p> <p>Windsor Ridge was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00178672.</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE